Methods and Standards for Establishing Payment Rates

Inpatient Hospital Services

The State has in place a public process which complies with the requirements of Section 1902 (a)(13)(A) of the Social Security Act. Except as noted below, all hospital services provided by Medicaid providers of inpatient hospital services are reimbursed under a DRG based prospective payment system (PPS).

A. **Hospital Services Subject to Reasonable Cost Reimbursement**
For hospital services subject to reasonable cost reimbursement, providers are paid on an interim basis by applying the, hospital's cost to charge ratio to allowed ~~drugs,~~ Billing must reflect the hospital's customary charge for the service rendered. Payments are subject to retrospective settlement and providers are paid the lesser of reasonable costs or total allowed charges. Payment is made for those items and services recognized as reasonable and allowable under Title XVIII standards and principles. Rules 5101:3-2-22, 5101:3-2-23 and 5101:3-2-24 of Appendix A detail provisions related to reasonable cost reimbursement. Hospital services subject to reasonable cost reimbursement include:

1. Freestanding rehabilitation hospitals which are excluded from the Medicare PPS.

2. Freestanding long-term hospitals which are excluded from the Medicare PPS.

3. Hospitals that are excluded from Medicare's PPS due to providing services, in total, which are excluded due to a combination of long-term care and rehabilitative services.

4. Hospitals licensed as HMOs which limit services to Medicaid recipients to those enrolled in an HMO or to short-term services provided on an emergency basis.

5. ~~Heart and liver transplantation services provided on and after October 1, 1986 and prior to September 3, 1991, bone marrow transplantations provided on or after October 19, 1987 and prior to September 3, 1991,~~ Heart/lung and pancreas transplantation services, ~~provided on or after October 1, 1996, and~~ single/double lung transplantation services provided on or after January 1, 1991 AND PRIOR TO FEBRUARY 1, 2000, AND LIVER/SMALL BOWEL TRANSPLANTATION SERVICES.

6. For all hospitals, capital-related costs are subject to reasonable cost related reimbursement.

7. Hospitals recognized by Medicare as cancer hospitals beginning with discharges on or after July 1, 1992.

B. Hospital Services Subject to Prospective Reimbursement:

For hospital services other than those described in (A), payments are made on a prospective per discharge basis. Although the payment rate is fixed in terms of not being subject to cost reconciliation (with the exception of capital-related costs), payment amounts will vary according to: the DRG to which the case is assigned; the peer group to which the hospital is assigned; the size and cost (as applicable) of a hospital's medical education program, where applicable; whether Norplant was provided, and finally, the degree to which a particular case is excessively lengthy or costly (outlier cases for which additional payments are made). The payment rate for a discharge is calculated as follows:

Average Cost Per Discharge Amount	**X**	**Relative Weight for the DRG**	**+**	**Add-On Amount for Capital**	**+**	**Add-On Amount for Medical Education**	**Add-On +Amount for Norplant**

Additional payments for outlier cases are made for cases which exceed outlier thresholds (see Section 5).

1. Calculation of the Average Cost per Discharge

The average cost per discharge (ACD) is calculated using inflated hospital base year cost report data (generally either calendar year 1985 or fiscal year 1986), subject to certain adjustments and limitations.

A hospital's Medicaid inpatient costs are standardized to include Medicaid's portion of malpractice costs reported on the 1986 Medicare cost report and to exclude a number of "non-operating" costs. Costs excluded are Medicaid inpatient capital, indirect medical education, and direct medical education. Capital and direct medical education costs are removed from total Medicaid inpatient costs by subtraction; indirect medical education costs are removed by dividing by 1 plus the hospital's indirect percentage. An additional standardization step is taken for hospitals in the major teaching hospital peer group to

remove the effect of varying wage rates since these hospitals are dispersed geographically throughout the state. These wage-sensitive costs are then brought back into payment rates using a wage factor specific to each wage area.

For hospitals with an ACD that exceeds cost-increase limits determined by the department, the ACD is reduced by 3 percent. The ACD is then inflated to account for varying hospital fiscal year ends and then divided by the hospital's base year DRG case mix index.

Finally a peer group average cost per discharge is determined for all hospitals other than children's hospitals. The PGACD is an average (weighted by Medicaid discharges) of the hospital-specific ACD of all hospitals in a peer group. Children's hospitals are priced on a hospital-specific basis, not subject to peer grouping. The Ohio peer groups are:

a. MSA Wage Related Peer Groups (9): Using Metropolitan Statistical Areas and wage indices published by the federal government, nine peer groups were identified by combining hospitals located in MSA's that carried wage indices within .01 of each other.

b. Non-MSAs (2): One peer group includes non-MSA area hospitals with less than 100 beds. A second non-MSA peer group includes non-MSA area hospitals with 100 beds or greater.

c. Teaching (1): One peer group includes hospitals with major/heavy teaching emphasis and hospitals recognized by Medicare as cancer hospitals until a cost report for the hospital has been reviewed. For State Fiscal years 1993 and 1994, the cancer hospital will be reimbursed on a reasonable cost basis.

d. Rural Referral Centers (1): Those hospitals which are recognized by Medicare as Rural Referral Centers are assigned to a separate peer group.

e. Non-Ohio Hospitals: Non-Ohio hospitals are classified into one of the three non-Ohio peer groups:

    1. Non-Ohio hospitals with a major heavy teaching emphasis;

    2. Non-Ohio Children's hospitals; or

3. All other non-Ohio hospitals. Rule 5101:3-2-072 in Appendix A describes the changes made to the non-Ohio payment policies.

Rule 5101:3-2-072 details provisions regarding classification of hospitals.

2. Adjustments to the Peer Group Average Cost per Discharge (Or Hospital-specific Average Cost per Discharge for Childrens Hospitals)

a. **Outlier Set-Aside:** An outlier set-aside is calculated on a hospital-specific basis for children's hospitals and hospitals in the major teaching peer group and on a peer group basis for all other hospitals. The set-aside amount is calculated by first repricing all of a hospital's claims during the period 7/1/85 through 6/30/86 using current prices, relative weights and outlier thresholds. Once claims are repriced, the sum of amounts of additional payments for outliers is divided by the sum of total payments for all cases (less payments for capital and medical education) plus payments for day outliers. In order to reduce the magnitude of the outlier set-aside for hospitals that experience a high volume of outlier cases, the sum of amounts of additional payments for outliers for any hospital with an outlier set-aside value greater than the statewide mean outlier set-aside value is reduced to 75 percent for the purpose of calculating a reduced set-aside.

The outlier set-aside adjustment is made by subtracting from the PGACD the product of the outlier set-aside percentage multiplied by the unadjusted ACD.

b. **Coding:** A coding adjustment is made by dividing the ACD (adjusted for outlier set-aside), by 1.005.

c. **Inflation:** The ACD (previously adjusted for varying fiscal year ends by inflating calendar year hospital's data through June 30, 1986) is inflated further at the beginning of each rate year as described in Rule 5101:3-2-074 of Appendix A.

3. Calculation of Add-on Amounts

a. **Medical Education:** Medical education costs, both direct and indirect,

are paid on a prospective basis. Calculation of both components of the medical education add-on include a test-of-reasonableness ceiling.

For direct medical education, the hospital's reported cost for interns and residents is divided by its reported number of FTE interns and residents. A statewide mean cost per intern/resident plus one standard/deviation is then determined using data from all hospitals with approved teaching programs. This value is the statewide ceiling of allowable reimbursable direct medical education costs. A hospital's allowable direct medical education costs are then divided by its number of Medicaid discharges in the base year to determine this portion of the medical education add-on.

Indirect medical education costs for a hospital are identified by applying the Medicare logarithmic formula to the hospital's resident-to-bed ratio. This formula produces a percentage which, when added to 1.0, is divided into Medicaid inpatient costs to standardize for indirect percentage (multiplied first by 100 to bring it to a whole number). This result, called the indirect "unit cost," is then used to determine a statewide mean unit cost plus one standard deviation. This amount is the ceiling for the allowable and reimbursable indirect medical education unit cost. The indirect add-on is then the allowable-indirect medical education percentage (multiplied again by 100 to bring it to a whole number) times the allowable unit cost. The direct and indirect medical education add-ons are summed and inflated for some hospitals for varying fiscal year ends. The total medical education add-on is then subject to the same inflation rates used to update the PGACD at the beginning of each rate year. For discharges on or after January 20, 1995, hospitals total medical education add-on is adjusted to remove the effects of case mix by dividing the hospital's inflated medical education add-on amount by the hospital's overall case mix as calculated in rule 5101:3-2-073. The adjusted medical education add-on is then adjusted for resource intensity of the inpatient admission by multiplying it by the corresponding DRG relative weight.

Rule 5101:3-2-077 of Appendix A details provisions regarding Medical Education.

b. **Capital:** Capital-related costs are subject to reasonable cost reimbursement. Interim rates are calculated by dividing base year

reimbursement. Interim rates are calculated by dividing base year capital-related costs by base year Medicaid discharges.

~~For the portion of a hospital's fiscal year that is prior to October 19, 1987, when capital was paid on a prospective basis, capital reimbursement will represent the product of discharges during that period times the capital allowance in effect as of July 3, 1986. Cost reimbursement will be made on a prorated basis for the otherwise allowable FY 88 capital-related costs.~~

Rule 5101:3-2-076 details provisions regarding capital-related costs.

c. **Norplant contraceptive devices inserted post delivery prior discharge from the hospital:** Reimbursement is contingent upon the inclusion in the medical record of a paper signed by the recipient at least 14 days prior to discharge stating that the recipient has been counseled concerning the various methods of birth control available and the recipient understands the complications and side effects that can occur with Norplant and that Norplant is the birth control method of choice.

Payment for Norplant will be made in accordance with the outpatient hospital fee schedule.

Rule 5101:3-2-071 details provisions regarding payment for Norplant.

4. Determination of Relative Weights and Associated DRG Data

a. Relative weights for DRGs and associated DRG values are calculated following methodology described in Rules 5101:3-2-073 and 5101:3-2-079 of Appendix A using all claims associated with discharges on or after September 1, 1993 through June 30, 1995 and paid by June 30, 1996 using the version of Medicare Grouper in effect during federal fiscal year 1998.

Relative weights for all DRGs except those with fewer than 10 cases are determined by first calculating:

- The average charge for a DRG and two standard deviations above the average.

- The average length of stay for a DRG and two standard deviations above the average.

Cases which are two standard deviations (one for neonatal DRGs) above either mean charge or length of stay are "removed" in order to recalculate:

- DRG average charge, without outliers.

- DRG average length of stay, without outliers.

The relative weight for a DRG is calculated by dividing average charge for a given DRG by average charges across all DRGs. Charge outlier thresholds are set by adding, for each DRG, the value of two standard deviations (one for neonatal DRGs) above the average Charge to the average Charge calculated without outliers. Day outlier thresholds are calculated by adding, for each DRG, the value of two standard deviations (one for neonatal DRGs) above the average length of stay to the average length of stay calculated without outliers.

b. Ohio Medicaid calculates relative weights and associated data for certain subsets of DRGs not classified in the Medicare Grouper as follows:

i. For DRGs 425 through 437, two sets of relative weights are calculated for each DRG. One set is calculated using data from hospitals which do not operate Medicare-approved psychiatric distinct part units while the other set is calculated using data from hospitals which do operate such units.

ii. For DRGs 388, 389 and 390, three subgroups are used for each DRG. For example, for DRG 388, one subgroup represents cases from hospitals with no Level II or III nursery, a second for cases from hospitals with a Level II nursery, and a third for cases from hospitals with a Level III nursery. Using this subgrouping criteria, three subgroups are created for each of DRGs 388, 389 and 390.

iii. For DRG 386, three subgroups are created, as follows:

a. Cases which have ICD-9-CM code 7650 (extreme

immaturity);

b. Cases which don't have ICD-9-CM code 7650 from hospitals with Level I or II nurseries;

c. Cases which don't have ICD-9-CM code 7650 from hospitals with Level III nurseries.

iv. For DRG 387, four subgroups are created, as follows:

a. Cases with a birthweight 0 to 1750 grams from hospitals with Level I or II nurseries;

b. Cases with a birthweight of 0 to 1750 grains from hospitals with Level III nurseries;

c. Cases with a birthweight of 1751 grams and above from hospitals with Level I or 11 nurseries;

d. Cases with a birthweight of 1751 grams and above from hospitals with Level III nurseries.

c. For DRGs with fewer than 10 cases, the relative weights are calculated by multiplying the percentage change in the case mix of the remaining DRGs resulting from the change from the Medicare grouper in effect during federal fiscal year 1993 as implemented on January 20, 1995 to the Medicare grouper in effect during federal fiscal year 1998 ~~1993~~ using the claims described in item 4 (a) of this plan, by the relative weight calculated using the grouper in effect during federal fiscal year 1998 ~~1993~~. The resulting values are identified in rule 5101:3-2-073.

For DRGs with more than no cases but fewer than 10 cases, outlier trims and mean lengths of stay are calculated as described. For DRGs with no cases grouped in the federal fiscal year 1998 ~~1993~~ grouper, previously calculated trims are used.

5. Calculation of Outlier Payments

a. **Day and Cost Outliers** - If a claim qualifies for additional day and cost outlier payments, day outlier payment takes precedence except for DRGs 385, 388, 389, and 892 through 898 (where cost outlier takes precedence over day outlier), and except for the special outlier payment policy described in 5.c below.

Day outliers are paid as follows:

(Average Cost 12er Discharge X Relative Weight for DRG) = Per Diem Amount
Average length of stay for DRG

[Per Diem Amount X Number of Days Above Day Threshold
X .60 (.80 for Neonatal DRGs)] = Day Outlier Additional Payment

Day Outlier Additional Payment + Regular DRG Payment =Total Reimbursement

Cost outliers are paid the lesser of the following:

(Billed Allowable Charges-Cost Outlier Threshold)X.60
(.80 for Neonatal DRGs) = Cost Outlier Additional Payment

Cost Outlier Additional Payment + Regular DRG Payment =Total Reimbursement

OR

Billed Allowable Charges X Hospital Specific Cost-To-Charge Ratio = Cost Outlier
Payment = Total Reimbursement

To determine a cost outlier for discharges on or after January 20, 1995, total allowable charges must be compared to the charge high trim.

For both day and cost outliers, if charges are less than the sum of regular DRG payment and the additional outlier payment, total payment is limited to billed charges.

b. **Extraordinary Outliers:** Hospitals that previously qualified for extraordinary outlier payments as such policy was in effect on July 3, 1986

may continue to be paid under that policy for stays exceeding 60 days with an admission date between July 3, 1986 and October 18, 1987. For admissions on or after October 19, 1987, a revised extraordinary outlier payment policy is in effect.

This payment policy provides that any hospital with a Medicaid claim exceeding $250,000 in cost will be paid on a cost-to-charge ratio basis. Cost is determined by applying the hospital's cost-to-charge ratio to allowed charges.

c. **Special Outlier Payment Policy** - Hospitals with outlier set-aside percent greater than one standard deviation above the statewide mean outlier percent and whose ratio of Medicaid, General Assistance and Title V inpatient days-to-total days, as described in Rule 5101:3-2-079 of Appendix A, is greater than one standard deviation above the statewide mean ratio qualify for special outlier payment policies. For such hospitals, cost outliers take precedence over day outliers in all cases and payment for cost outliers is based on 85 percent of cost. Cost is determined by applying the hospital's cost-to-charge ratio to allowed claim charges.

For hospital serving an AIDS patient population two standard deviations above the statewide mean ratio of hospital AIDS cases to total aids cases, cost outlier will take precedence over day outlier for DRGs 488-490. Payment for those cost outliers will be 85 percent of total allowable claim cost.

Rule 5101:3-2-079 details provisions regarding outlier payments.

6. **Special Payment Provisions**

a. **Transfers and Partial Eligibility:** In cases when a patient is transferred from one hospital to another, payment is made to each hospital on a per diem ~~them~~ basis. Similarly, when a patient is Medicaid eligible for only a portion of an inpatient stay, payment is made on a per ~~them~~ basis, when Am's calculated as follows:

(Average Cost Per Discharge X Relative Weight For DRG) = Per Diem Amount
Average Length of Stay for DRG

[(Per Diem Amount X Number of Covered Days) + Medical Education Add-On + Capital Add-On] = Total Per Diem DRG Payment